

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 16, Film G-238 1/29/59.cac.

Reg. Dist. No.

00662

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Harford 696		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton RD		c. LENGTH OF STAY IN 1b X SPARKSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 146 NEAR Taylor		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) John Leroy Adams Jr		4. DATE OF DEATH Month January Day 24 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug 2 1929
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Operator of Gas Products		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) U.S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.C.	
13. FATHER'S NAME John Leroy Adams		14. MOTHER'S MAIDEN NAME Hola Ray Copenhagen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-28-8820	
17. INFORMANT Mrs. Hola R. Adams White Hall MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull .819x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, auto - object type	
20c. TIME OF INJURY Month, Day, Year 1-24-59 Hour 2 a. m. 1 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 146		20f. (City or town) (County) (State) Monkton Harford MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air MD	
EXAMINER'S NAME (Type) Gerald C Palmer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 1-24-59	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Jan 27-59	
22c. NAME OF CEMETERY OR CREMATORY Bethel		22d. LOCATION (City, town, or county) (State) Madonna Harford MD	
23. FUNERAL DIRECTOR'S SIGNATURE Marion Spink Lane		24a. REC'D BY REGISTRAR DATE JAN 29 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE William S. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director or, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
DISEASE OR INJURY		LOCALITY		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE	
HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		RADIOLOGICAL EXAMINATIONS		PATHOLOGICAL EXAMINATIONS		OTHER EXAMINATIONS	
POST-MORTEM EXAMINATION		AUTOPSY		TOXICOLOGY		BACTERIOLOGY		VIRUS		OTHER	
SIGNATURE OF EXAMINER		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF JURY		DATE	

CERTIFICATE OF DEATH

0066

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u>	LENGTH OF STAY (in this place) <u>6 Mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Norrisville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescing Home</u>		STREET ADDRESS (If rural give location) <u>Bel Air, Md. White Hall RD</u>	
3. NAME OF DECEASED (Type or Print) <u>Luella E. Almony</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 3 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 1865</u>
9. AGE last birthday <u>93</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas J. Ayres</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Norris</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Arnold Ayres Fawn Grove, Pa.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4-2-1 IMMEDIATE CAUSE (A) <u>Hypostatic Pneumonia</u>			<u>6 Mo.</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Cardio Vascular Disease</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 1, 1958</u> , to <u>Jan. 2, 1959</u> , that I last saw the deceased alive on <u>Jan. 2, 1959</u> , and that death occurred at <u>11:30 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Willard P. Hudson</u> M.D.		ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>	
DATE SIGNED <u>Jan. 5, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/6/1959</u>	NAME OF CEMETERY OR CREMATORY <u>Ayres Chapel</u>	LOCATION (City, town, or county) <u>White Hall RD Md.</u>
24. REC'D BY REGISTRAR <u>JAN 7 '59</u>	REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Kury</u>	ADDRESS <u>Parrettsville Md.</u>

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

671 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Horne-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>R. Luke (Luca) Amato</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard Amato</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Alagia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-8090</u>	
17. INFORMANT <u>Rita Amato, Perryville, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Bronchopneumonia</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/25</u> , 19 <u>58</u> , to <u>1-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-2</u> , 19 <u>59</u> , and that death occurred at <u>10:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G.H. Richards Jr.</u>		DATE SIGNED <u>1-2-59</u>	
PHYSICIAN'S NAME (Type) <u>G.H. Richards Jr.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-5-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Erin Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>havre De Grace, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leea, Patterson & Sons</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 6 '59</u>	
ADDRESS <u>Perryville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneen</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00665

Reg. Dist. No.

672

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First W. Middle AMREIN Last		4. DATE OF DEATH Month January Day 8 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 15, 1908	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Harford County		11. BIRTHPLACE (State or foreign country) Jarrettsville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles H. Amrein				14. MOTHER'S MAIDEN NAME Mary A. Eicholtz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 213-20-5968		17. INFORMANT Henrey Amrein Forest Hill, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/8/59			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/59		22c. NAME OF CEMETERY OR CREMATORY Wm. Watters		22d. LOCATION (City, town, or county) (State) Coopertown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles C. Kurtz				24a. REC'D BY REGISTRAR DATE JAN 12 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

HARFORD

Harford General Hospital

DATE OF DEATH
1944

SEX

MALE

WHITE

Causes of Death
Pneumonia
Coronary Arteriosclerosis

1. I certify that the above is a true and correct statement of the facts as to the death of the deceased.
☐ I am a physician and surgeon.
☐ I am a medical examiner.
☒ I am a coroner.
☐ I am a justice of the peace.
☐ I am a member of the board of health.
☐ I am a member of the board of directors of the health department.

2. I certify that the above is a true and correct statement of the facts as to the death of the deceased.
☐ I am a physician and surgeon.
☐ I am a medical examiner.
☒ I am a coroner.
☐ I am a justice of the peace.
☐ I am a member of the board of health.
☐ I am a member of the board of directors of the health department.

3. I certify that the above is a true and correct statement of the facts as to the death of the deceased.
☐ I am a physician and surgeon.
☐ I am a medical examiner.
☒ I am a coroner.
☐ I am a justice of the peace.
☐ I am a member of the board of health.
☐ I am a member of the board of directors of the health department.

4. I certify that the above is a true and correct statement of the facts as to the death of the deceased.
☐ I am a physician and surgeon.
☐ I am a medical examiner.
☒ I am a coroner.
☐ I am a justice of the peace.
☐ I am a member of the board of health.
☐ I am a member of the board of directors of the health department.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00666

697

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air, R.D.,</u>			c. LENGTH OF STAY IN 1b <u>7 mos.,</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescing Home</u>			d. STREET ADDRESS <u>Bradshaw</u> <u>03X-2</u>		
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>S.</u> Last <u>Bartkowiak</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>31,</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16, 1880</u>		9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-30-2272</u>		17. INFORMANT <u>Mrs. Geo., A. Kahl</u> Address <u>Fullerton, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>12 yrs.</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County) (State)			
21. I certify that I attended the deceased from <u>June 3, 1958</u> to <u>Jan 31, 1959</u> , that I last saw the deceased alive on <u>Jan 30, 1959</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Fork Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D. PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u> <u>FORK MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens</u>	
22d. LOCATION (City, town, or county)		(State) <u>Bradshaw, Balto., Maryland.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Williams</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Name of Informant	
George Bearach		Gerald C. Palmer	
Relationship		Relationship	
Brother		Brother	
Date of Birth		Date of Birth	
Jan. 2, 1929		Jan. 2, 1929	
Place of Birth		Place of Birth	
Bel Air, Maryland		Bel Air, Maryland	
Race		Race	
White		White	
Sex		Sex	
Male		Male	
Occupation		Occupation	
Merchant		Merchant	
Date of Death		Date of Death	
Aug. 20, 1957		Aug. 20, 1957	
Place of Death		Place of Death	
Harford Memorial Hospital		Harford Memorial Hospital	
Cause of Death		Cause of Death	
Myocardial Infarction		Myocardial Infarction	
Manner of Death		Manner of Death	
Natural		Natural	
Signature of Informant		Signature of Informant	
Gerald C. Palmer		Gerald C. Palmer	
Signature of Physician		Signature of Physician	
Trinity Lutheran		Trinity Lutheran	
Signature of Registrar		Signature of Registrar	
John C. Palmer		John C. Palmer	

698 **CERTIFICATE OF DEATH**

00668

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) RURAL, Bel Air		LENGTH OF STAY (in this place) 5 months		CITY (If outside corporate limits, write RURAL and give nearest town) RURAL - Bel Air			
HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD #2, Bel Air				STREET ADDRESS (If rural give location) c/o Ernest B. Kirkpatrick, Bel Air		RFD #2,	
3. NAME OF DECEASED (Type or Print) (First) CHRISTIANA (Middle) CATHERINE (Last) BEVANS				4. DATE OF DEATH (Month) January (Day) 3, (Year) 19 59			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH November 18, 1876	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harman Schlissler				14. MOTHER'S MAIDEN NAME Catherine Kate			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. --		17. INFORMANT & ADDRESS son-in-law: E. B. Kirkpatrick, RD #2, Bel Air, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4221 IMMEDIATE CAUSE (A) Congestive heart failure				INTERVAL BETWEEN ONSET AND DEATH 1 hour			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic cardiovascular disease				several years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 1) recent cerebral thrombosis 2) fracture of right hip				2 or 3 weeks 6 months			
19a. DATE OF OPERATION --		19b. MAJOR FINDINGS OF OPERATION --		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from August 24, 19 58 , to Jan. 3, 19 59 , that I last saw the deceased alive on Dec. 30, 19 58 , and that death occurred at 12:50 M, from the causes and on the date stated above.							
SIGNATURE Paul S. Stonestifer, Jr.		DATE THEREOF 1-6-59		NAME OF CEMETERY OR CREMATORY Meadow Ridge		LOCATION (City, town, or county) Bel Air Md	
23. (BURIAL) CREMATION, REMOVAL (SPECIFY)		REGISTRAR'S SIGNATURE Paul S. Stonestifer, Jr.		25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Huck		ADDRESS 5305 Harford	
DATE JAN 6 '59							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN WHO ATTENDS THE DECEASED. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH-BALTIMORE. 12

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH November 1, 1960		5. TIME OF DEATH 10:15 A.M.		6. PLACE OF DEATH Home	
7. OCCUPATION Retired		8. MARITAL STATUS Married		9. EDUCATION High School	
10. BIRTH DATE October 1, 1895		11. BIRTH PLACE Maryland		12. RACE White	
13. PRESENT ADDRESS 1500 North Avenue, Baltimore, Md.		14. PRESENT PHONE 781-1234		15. PRESENT MAILING ADDRESS Same as present address	
16. PHYSICIAN'S NAME Dr. J. H. Smith		17. PHYSICIAN'S ADDRESS 123 Main Street, Baltimore, Md.		18. PHYSICIAN'S PHONE 781-5678	
19. CAUSE OF DEATH Myocardial infarction		20. MANNER OF DEATH Natural		21. MEDICAL HISTORY Hypertension, Diabetes	
22. SIGNATURE OF PHYSICIAN J. H. Smith		23. SIGNATURE OF DECEASED (If living)		24. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00669

699

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE Maryland		COUNTY Harford			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN RURAL - Forest Hill		lifetime		TOWN RURAL -- Forest Hill			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 215, RFD, Forest Hill				STREET ADDRESS (If rural give location) Box 215, RFD, Forest Hill			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JAMES (Middle) HENRY (Last) BLAKE				(Month) January (Day) 31 (Year) 19 59			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	10. IF UNDER 1 YEAR	
male	white	married	October 29, 1877		81 yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Farming		Maryland		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Blake				Martha O'Donnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		219-36-0214		Alvin Blake (son) Box 215, RFD, Forest Hill, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Myocardial Infarction						6 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Coronary thrombosis						6 hrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic cardiovascular disease						4 - 5 yrs.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Residual of cerebrovascular accident						18 months	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 31, 19 59, to ---, 19 ---, that I last saw the deceased alive on ---, 19 ---, and that death occurred at 12:05 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)				DATE SIGNED	
Paul S. Stonesifer, Jr. Deputy Medical Examiner		Harford, Md.				1/31/59	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 3, 1959		St. Ignatious Cemetary		Hickory (Harford) Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
				Joseph W. Foster W. Broadway + Williams St. BEL AIR, Maryland			
DATE FEB 3 '59							

CERTIFICATE OF DEATH

689

Reg. Dist. No.

NAME OF DECEASED

John Henry

John Henry

Age

Age

Sex

Sex

Color

Color

Place of Birth

Place of Birth

Married

Married

Occupation

Occupation

Usual Residence

Usual Residence

Place of Death

Place of Death

Date of Death

Date of Death

Time of Death

Time of Death

Cause of Death

Cause of Death

Medical Attendant

Medical Attendant

Signature of Medical Attendant

Signature of Medical Attendant

Signature of Registrar

Signature of Registrar

Signature of Coroner

Signature of Coroner

Signature of Burial Officer

Signature of Burial Officer

Signature of Undertaker

Signature of Undertaker

Signature of Minister

Signature of Minister

Signature of Priest

Signature of Priest

RECEIVED

RECEIVED
BALTIMORE, MD.
JAN 10 1910
STATE DEPARTMENT OF HEALTH

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

700 CERTIFICATE OF DEATH

00070

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>	
CITY OR TOWN <u>Fallston</u>		LENGTH OF STAY (in this place) <u>15 yrs.</u>		TOWN <u>RD</u>		STREET ADDRESS (If rural give location) <u>Plesantville Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Cora Leeanza Blevins</u>				<u>Jan. 7 1959</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Oct. 15, 1871</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Lansing N.C.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Francis</u>				<u>Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>-----</u>		<u>Miss. Francis Blevins Fallston Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>4340</u> IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Extreme Thoraco-Lumbar Kyphosis</u>				Prob. <u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Osteo Arthritis</u>				32 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 3</u>, 19<u>59</u>, to <u>Jan. 7</u>, 19<u>59</u>, that I last saw the deceased alive on <u>Jan. 6</u>, 19<u>59</u>, and that death occurred at <u>5</u> <u>a.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>Jan. 7, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/9/1959</u>		<u>Oak Grove</u>		<u>Fountain Green Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 12 '59</u>		<u>Charles E. K...</u>		<u>Morton G. K...</u>		<u>San Th...</u>	

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. MARITAL STATUS

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF WITNESSES

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF DEATH

18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF CORONER

20. SIGNATURE OF WITNESSES

21. DATE OF DEATH

22. TIME OF DEATH

23. PLACE OF DEATH

24. SIGNATURE OF PHYSICIAN

25. SIGNATURE OF CORONER

26. SIGNATURE OF WITNESSES

27. DATE OF DEATH

28. TIME OF DEATH

29. PLACE OF DEATH

30. SIGNATURE OF PHYSICIAN

31. SIGNATURE OF CORONER

32. SIGNATURE OF WITNESSES

33. DATE OF DEATH

34. TIME OF DEATH

35. PLACE OF DEATH

36. SIGNATURE OF PHYSICIAN

37. SIGNATURE OF CORONER

38. SIGNATURE OF WITNESSES

39. DATE OF DEATH

40. TIME OF DEATH

41. PLACE OF DEATH

42. SIGNATURE OF PHYSICIAN

43. SIGNATURE OF CORONER

44. SIGNATURE OF WITNESSES

45. DATE OF DEATH

46. TIME OF DEATH

47. PLACE OF DEATH

48. SIGNATURE OF PHYSICIAN

49. SIGNATURE OF CORONER

50. SIGNATURE OF WITNESSES

51. DATE OF DEATH

52. TIME OF DEATH

53. PLACE OF DEATH

54. SIGNATURE OF PHYSICIAN

55. SIGNATURE OF CORONER

56. SIGNATURE OF WITNESSES

57. DATE OF DEATH

58. TIME OF DEATH

59. PLACE OF DEATH

60. SIGNATURE OF PHYSICIAN

61. SIGNATURE OF CORONER

62. SIGNATURE OF WITNESSES

63. DATE OF DEATH

64. TIME OF DEATH

65. PLACE OF DEATH

66. SIGNATURE OF PHYSICIAN

67. SIGNATURE OF CORONER

68. SIGNATURE OF WITNESSES

69. DATE OF DEATH

70. TIME OF DEATH

71. PLACE OF DEATH

72. SIGNATURE OF PHYSICIAN

73. SIGNATURE OF CORONER

74. SIGNATURE OF WITNESSES

75. DATE OF DEATH

76. TIME OF DEATH

77. PLACE OF DEATH

78. SIGNATURE OF PHYSICIAN

79. SIGNATURE OF CORONER

80. SIGNATURE OF WITNESSES

81. DATE OF DEATH

82. TIME OF DEATH

83. PLACE OF DEATH

84. SIGNATURE OF PHYSICIAN

85. SIGNATURE OF CORONER

86. SIGNATURE OF WITNESSES

87. DATE OF DEATH

88. TIME OF DEATH

89. PLACE OF DEATH

90. SIGNATURE OF PHYSICIAN

91. SIGNATURE OF CORONER

92. SIGNATURE OF WITNESSES

93. DATE OF DEATH

94. TIME OF DEATH

95. PLACE OF DEATH

96. SIGNATURE OF PHYSICIAN

97. SIGNATURE OF CORONER

98. SIGNATURE OF WITNESSES

99. DATE OF DEATH

100. TIME OF DEATH

101. PLACE OF DEATH

102. SIGNATURE OF PHYSICIAN

103. SIGNATURE OF CORONER

104. SIGNATURE OF WITNESSES

105. DATE OF DEATH

106. TIME OF DEATH

107. PLACE OF DEATH

108. SIGNATURE OF PHYSICIAN

109. SIGNATURE OF CORONER

110. SIGNATURE OF WITNESSES

111. DATE OF DEATH

112. TIME OF DEATH

113. PLACE OF DEATH

114. SIGNATURE OF PHYSICIAN

115. SIGNATURE OF CORONER

116. SIGNATURE OF WITNESSES

117. DATE OF DEATH

118. TIME OF DEATH

119. PLACE OF DEATH

120. SIGNATURE OF PHYSICIAN

121. SIGNATURE OF CORONER

122. SIGNATURE OF WITNESSES

123. DATE OF DEATH

124. TIME OF DEATH

125. PLACE OF DEATH

126. SIGNATURE OF PHYSICIAN

127. SIGNATURE OF CORONER

128. SIGNATURE OF WITNESSES

129. DATE OF DEATH

130. TIME OF DEATH

131. PLACE OF DEATH

132. SIGNATURE OF PHYSICIAN

133. SIGNATURE OF CORONER

134. SIGNATURE OF WITNESSES

135. DATE OF DEATH

136. TIME OF DEATH

137. PLACE OF DEATH

138. SIGNATURE OF PHYSICIAN

139. SIGNATURE OF CORONER

140. SIGNATURE OF WITNESSES

141. DATE OF DEATH

142. TIME OF DEATH

143. PLACE OF DEATH

144. SIGNATURE OF PHYSICIAN

145. SIGNATURE OF CORONER

146. SIGNATURE OF WITNESSES

147. DATE OF DEATH

148. TIME OF DEATH

149. PLACE OF DEATH

150. SIGNATURE OF PHYSICIAN

151. SIGNATURE OF CORONER

152. SIGNATURE OF WITNESSES

701

CERTIFICATE OF DEATH

00671

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	c. LENGTH OF STAY IN 1b <i>Life long</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air, Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bel Air</i>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Dennis</i> Middle <i>Leo</i> Last <i>Bradley</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>8</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 17 - 1874</i>
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanical</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Water Company</i>	11. BIRTHPLACE (State or foreign country) <i>Talbot, Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>US</i>		13. FATHER'S NAME <i>Daniel Bradley</i>	
14. MOTHER'S MAIDEN NAME <i>Maria Jahany</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>215-03-3259</i>		17. INFORMANT Address <i>Mrs. Alice V. Bradley - Bel Air Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO-RESP. FAILURE</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ADVANCED ARTERIO SCLEROSIS + CONGESTIVE</i> DUE TO (c) <i>HEART FAILURE</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 DAYS</i> <i>2 YEARS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1952</i> , to <i>8 Jan</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>7 Jan</i> , 19 <i>59</i> , and that death occurred at <i>2:17 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H.P. Adwell</i>		M.D. <i>401 Franklin St. Bel Air Md Jan 8</i>	
PHYSICIAN'S NAME (Type) <i>H.P. SIDWELL M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Jan 12, 1959</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>St. John's Catholic</i>	22d. LOCATION (City, town, or county) (State) <i>Long Green Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.H. Archer</i>		ADDRESS <i>Benson, Md.</i>	
24a. REC'D BY REGISTRAR <i>JAN 12 1959</i>		DATE	
24b. REGISTRAR'S SIGNATURE <i>Wm. S. Hume</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

674

CERTIFICATE OF DEATH

00672

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 5 HRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 BELAIR			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.				d. STREET ADDRESS 113 N. REID			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MAMIE Middle BOLLES Last CARSWELL				4. DATE OF DEATH Month JANUARY Day 24 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1874	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Hiram Bolles				14. MOTHER'S MAIDEN NAME Emily VAN METER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Mary C. Mansion	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease (c) and Hypertensive Cardiovascular Disease (?)				INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 1 Day 23 Year 1959 Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 123rd				20g. (County) Harford		20h. (State) Md.	
21. I certify that I attended the deceased from 1/23rd , 19 59 to 1/24 , 19 59 that I last saw the deceased alive on 1/24th , 19 59 and that death occurred at 12:30 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave.			
DATE SIGNED 1/24/59							
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				ADDRESS Haure de Grace Ind.			
22a. BURIAL-CREATION-REMOVAL (Specify) Jan 26, 1959				22b. DATE THEREOF Springfield		22c. NAME OF CEMETERY OR CREMATORY St. Ignace	
22d. LOCATION (City, town, or county) St. Ignace				22e. (State) Illinois			
23. FUNERAL DIRECTOR'S SIGNATURE H.S. Bailey				ADDRESS Harlington, Md.		24a. REC'D BY REGISTRAR DATE JAN 28 1959	
24b. REGISTRAR'S SIGNATURE Arthur E. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 006773/82

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Walter Chamberlain</u>		4. DATE OF DEATH <u>Jan 27</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1883</u>
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer on farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Chamberlain</u>		14. MOTHER'S MAIDEN NAME <u>Laura Fernwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-32-2</u>	
17. INFORMANT <u>Mr. Lucy Scarborough</u>		Address <u>186 Street, 17714</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24h</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 1958</u> , to <u>Jan 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips M.D.</u>		DATE SIGNED <u>1/29/59</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>		ADDRESS (Street, city or town, state) <u>Darlington Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 31, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Kubler Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Darlington Md</u>	
24a. REC'D BY REGISTRAR <u>5</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

10

675

CERTIFICATE OF DEATH

Reg. Dist. No.

00674

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shore of Peace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NEIL</u> Middle <u>XXXXX</u> Last <u>Franklin Collier</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 June 1895</u>
9. AGE (In years day birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>	
11. BIRTHPLACE (State or foreign country) <u>Vergina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Creed F. Collier</u>		14. MOTHER'S MAIDEN NAME <u>Willie Ann Edens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>233 09 9317</u>	
17. INFORMANT <u>Richard Collier - son -</u> Address <u>158 E. Allen St - Aberdeen</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma (primary)</u> <u>154X</u> DUE TO <u>rectum - status remate resection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>18 mo.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October</u> , 19 <u>59</u> , to <u>1-9-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-9-</u> , 19 <u>59</u> , and that death occurred at <u>8:25 am</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.		ADDRESS (Street, city or town, state) <u>8 Law Street</u> DATE SIGNED <u>1-10-59</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		<u>Aberdeen, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens, Bel Air, Maryland</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u> ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>

Tarring Funeral Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

832

NAME OF DECEASED WILLIAM J. JONES		AGE 42		SEX M		RACE W		DATE OF DEATH June 10, 1902		PLACE OF DEATH Home	
RESIDENCE No. 1234, Street, Baltimore, Md.		OCCUPATION Coal Miner		CAUSE OF DEATH Pneumonia		MANNER OF DEATH Natural		DATE OF BURIAL June 12, 1902		PLACE OF BURIAL St. John's Church	
FATHER'S NAME John J. Jones		MOTHER'S NAME Mary J. Jones		BIRTH DATE June 10, 1860		BIRTH PLACE Maryland		EDUCATION Common School		RELIGION Roman Catholic	
PREVIOUS ILLNESS None		PREVIOUS SURGERY None		PREVIOUS TRAUMA None		PREVIOUS TOXICITY None		PREVIOUS INFECTION None		PREVIOUS OTHER None	
SIGNATURE OF PHYSICIAN J. H. Jones, M.D.		SIGNATURE OF FUNERAL DIRECTOR J. H. Jones		SIGNATURE OF WITNESS J. H. Jones		SIGNATURE OF WITNESS J. H. Jones		SIGNATURE OF WITNESS J. H. Jones		SIGNATURE OF WITNESS J. H. Jones	

703

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY Cabell	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		c. LENGTH OF STAY IN 1b 12 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, Aberdeen Prov.Gd., Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milton, West Virginia	
f. STREET ADDRESS Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose Baxter Cunningham		4. DATE OF DEATH January 14 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 December 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Felix Josephus Baxter		14. MOTHER'S MAIDEN NAME Sarah Prudence Duffy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT LtCol Harvey M. Hardin, Aberdeen Proving Gd., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma DUE TO (c) Carcinoma of breast			
INTERVAL BETWEEN ONSET AND DEATH 4 days Unknown 1.5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Megaloblastic anemia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury or accident	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 January, 1959 , to Death, 14 Jan 59 , that I last saw the deceased alive on 5:30 PM, 14 Jan 19 59 , and that death occurred at 10:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE D. Hamaty		ADDRESS (Street, city or town, state) Aberdeen Proving Ground, Maryland	
PHYSICIAN'S NAME (Type) DANIEL HAMATY, Capt. MC		DATE SIGNED 14 Jan 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 1/15/1959	22c. NAME OF CEMETERY OR CREMATORY Auttoh Cemetery	22d. LOCATION (City, town, or county) (State) Auttoh, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE John P. Barring		24a. REC'D BY REGISTRAR DATE JAN 19 '59	
ADDRESS Aberdeen, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100-100

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of burial place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
29. Signature of burial place		30. Signature of burial place		31. Signature of burial place		32. Signature of burial place	
33. Signature of burial place		34. Signature of burial place		35. Signature of burial place		36. Signature of burial place	
37. Signature of burial place		38. Signature of burial place		39. Signature of burial place		40. Signature of burial place	
41. Signature of burial place		42. Signature of burial place		43. Signature of burial place		44. Signature of burial place	
45. Signature of burial place		46. Signature of burial place		47. Signature of burial place		48. Signature of burial place	
49. Signature of burial place		50. Signature of burial place		51. Signature of burial place		52. Signature of burial place	
53. Signature of burial place		54. Signature of burial place		55. Signature of burial place		56. Signature of burial place	
57. Signature of burial place		58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place		64. Signature of burial place	
65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place		76. Signature of burial place	
77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
81. Signature of burial place		82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place		88. Signature of burial place	
89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

676

CERTIFICATE OF DEATH

00676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>1 HR. 50 MIN.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>HERBERT J DAVIS</u>		4. DATE OF DEATH <u>JANUARY 28 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1901</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Riley DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>Dilly COBLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-09-7743</u>	
17. INFORMANT <u>Mrs. Anna Davis</u>		Address <u>Bel Air, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterolateral myocardial infarction</u> 420.1 DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> 2 years (c) <u>Arteriosclerotic Cardiovascular Disease</u> 2 years		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 28th, 1959</u> to <u>Jan 28th, 1959</u> that I last saw the deceased alive on <u>1:30 PM 1/28/59</u> and that death occurred at <u>11:35 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Bel Air, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		DATE SIGNED <u>1/28/59 11:45 PM</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 1, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McComas</u>		24a. REC'D BY REGISTRAR <u>FEB 2 '59</u>	
ADDRESS <u>Abingdon, Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Plummer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

678

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1901

<p>1. NAME OF DECEASED Mrs. Anna Davis</p>		<p>2. SEX Female</p>	
<p>3. AGE 27</p>		<p>4. DATE OF BIRTH Aug. 1, 1901</p>	
<p>5. PLACE OF BIRTH Bel Air, Maryland.</p>		<p>6. STATE OF BIRTH Maryland</p>	
<p>7. OCCUPATION None</p>		<p>8. MARITAL STATUS Single</p>	
<p>9. CAUSE OF DEATH (To be filled by physician)</p>		<p>10. PLACE OF DEATH Bel Air, Maryland.</p>	
<p>11. DATE OF DEATH Feb. 1, 1902</p>		<p>12. TIME OF DEATH 10:00 AM</p>	
<p>13. SIGNATURE OF PHYSICIAN W. E. Vion</p>		<p>14. SIGNATURE OF REGISTRAR J. H. Vion</p>	
<p>15. CITY OF DEATH Bel Air, Maryland.</p>		<p>16. COUNTY OF DEATH Harford, Maryland.</p>	

may be relayed to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

704

CERTIFICATE OF DEATH

00677

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>High Point</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>High Point</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Oliver Foard</u>				4. DATE OF DEATH Month Day Year <u>January 11 19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1880</u>		9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Pleasantville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver S. Foard</u>				14. MOTHER'S MAIDEN NAME <u>Mary Harkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-36-8099</u>		17. INFORMANT <u>F. Russell Foard Forest Hill Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia, terminating</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 7</u> , 19 <u>58</u> , to <u>Jan. 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 10</u> , 19 <u>59</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>1/12/59</u>							
ACTUAL SIGNATURE <u>Willard P. Hudson</u>				PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/13/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Centre</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Hill Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martine Kintz</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00678

705 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Putnam Rd</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Putnam Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>Forest Hill Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ANNE GRAY</u>				4. DATE OF DEATH Month Day Year <u>JAN 31 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 23, 1919</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wheatland T. Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Marie E. Rudd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Frances A. Gray Forest Hill Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X CORONARY OCCLUSION</u> DUE TO <u>of coronary ostia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY insufficiency due to scarring</u> DUE TO (c) <u>Rheumatic carditis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>13 YRS</u> <u>30 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept</u> 19 <u>55</u> , to <u>31 JAN</u> 19 <u>59</u> , that I last saw the deceased alive on <u>31 JAN</u> 19 <u>59</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thos. A. E. Moseley Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>JARRETTVILLE</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>THOS. A. E. MOSELEY, JR.</u>				<u>MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb 3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Rest</u>		22d. LOCATION (City, town, or county) (State) <u>La Plata Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David M. Galt</u> ADDRESS <u>Jarrettville</u>				24a. REC'D BY REGISTRAR <u>DATE B 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

706

CERTIFICATE OF DEATH

00679

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Fallston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Fallston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rural Friendship Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>White</u> Last <u>Guild</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 29, 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Arkansas City - Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Oliver Hill White</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Hill - Kansas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Stacy R. Guild - Fallston Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1:30 Jan 16 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Fallston Harford Md</u>	
21. I certify that I attended the deceased from <u>April</u> , 1953, to <u>Jan</u> , 1959, that I last saw the deceased alive on <u>Jan 14</u> , 1959, and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lay Martin</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 1201 Calvert St Baltimore Md Jan 16/59</u>	
PHYSICIAN'S NAME (Type) <u>Lay Martin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Jan 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bremont</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W H Archer - Benson Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 23 '59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARTS AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

707

CERTIFICATE OF DEATH

Reg. Dist. No.

00680

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 31			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Gunther Last Gunther				4. DATE OF DEATH Month Jan. Day 22 Year 19 59			
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1871	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 22 Days 19 Hours 59	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Bessie Gunther Address Aberdeen, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Generalized Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Bronchitis (c) Chronic Bronchitis						INTERVAL BETWEEN ONSET AND DEATH 2 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 17, 1958 , to Jan. 22, 1959 , that I last saw the deceased alive on Jan. 22, 1959 , and that death occurred at Jan. 22, 1959 , M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Andre Weiss M.D.				ADDRESS (Street, city or town, state) 114 W. Bel Air Av. Aberdeen, Md.			
PHYSICIAN'S NAME (Type) ANDRE WEISS MD				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombs				ADDRESS Abingdon, Maryland		24a. REC'D BY REGISTRAR JAN 27 '59	
				24b. REGISTRAR'S SIGNATURE Charles S. Kneiss			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1917

Hartford

Maryland

Anderson

Hartford

Anderson

Jan.

Gunter

Thomas

87

Mar. 17, 1871

W

white

male

Hartford Co., Maryland

Garret

Farmer

Anderson

Anderson

Anderson, Maryland

Miss Beale Gunter

none

no

Cocke's Memorial

Jan. 22, 1917

Baltimore

Baltimore, Maryland

Baltimore, Maryland

708

CERTIFICATE OF DEATH

00681

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>RD 1</u>		d. STREET ADDRESS <u>RD 1</u>	
3. NAME OF DECEASED (Type or print) <u>Charles William Hall</u>		4. DATE OF DEATH <u>January 2</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1888</u>
9. AGE (In years, lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>21</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Board of Education</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Will Hall</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Hopkins Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>232-05-0067</u>	
17. INFORMANT <u>Mrs. Mabel Hart</u>		Address <u>612 South Union Ave. Harford, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-29-58</u> to <u>1-2</u> 19 <u>59</u> that I last saw the deceased alive on <u>1-1-</u> 19 <u>59</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air Md</u> DATE SIGNED <u>1-2-59</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 5, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Churchville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E Bulluck</u>		ADDRESS <u>Harford Grace, Md</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

709

CERTIFICATE OF DEATH

00682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle HARRIS Last HARRIS				4. DATE OF DEATH Month January Day 13 Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 October 1881		9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Dishwashing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (Unknown)				14. MOTHER'S MAIDEN NAME Elizabeth Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-07-7310		17. INFORMANT Address Mary Hollingsworth, Perryman, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease (c) Hypertensive Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 22, 19 58 , to Jan. 12, 19 59 , that I last saw the deceased alive on January 12, 19 59 , and that death occurred at 12:20 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE George T. Stansbury				M.D. 569 Revolution St.		DATE SIGNED 1-14-59	
PHYSICIAN'S NAME (Type) George T. Stansbury				M.D. Hayre de Grace, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-16-59		22c. NAME OF CEMETERY OR CREMATORY Ashury Cemetery		22d. LOCATION (City, town, or county) (State) Loreley, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Larring				ADDRESS Farring Funeral Home Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. H.	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00683

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN <u>1 hour</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie Louella Harrison</u>		4. DATE OF DEATH <u>January 17, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 29, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NEB.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Minnie Simpers</u>		Address <u>ELKTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to tracheal obstruction</u> 921.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>obstruction</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Choked on piece of liner</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-17-59</u> Hour <u>—</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Harford</u> (County) <u>Harford</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Rel Air</u> DATE SIGNED <u>1-18-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 20, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEM.</u>		22d. LOCATION (City, town, or county) <u>ELKTON, MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>HAVRE DE GRACE, MD</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. —</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1900

Age

Sex

Color

Marital Status

Occupation

Education

Religion

Place of Birth

Usual Residence

Present Residence

Time of Death

Place of Death

Cause of Death

Manner of Death

Signature of Medical Examiner

Date

Signature of Coroner

Date

Signature of Registrar

Date

Signature of Physician

Date

Signature of Nurse

Date

Signature of Undertaker

Date

Signature of Burial Officer

Date

Signature of Cemetery Officer

Date

Signature of Health Officer

Date

Signature of Medical Examiner

Date

Signature of Coroner

Date

Signature of Registrar

Date

Signature of Physician

Date

Signature of Nurse

Date

Signature of Undertaker

Date

Signature of Burial Officer

Date

Signature of Cemetery Officer

Date

678

CERTIFICATE OF DEATH

00684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRYVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.				d. STREET ADDRESS Box # 36			
3. NAME OF DECEASED (Type or print) First Middle Last Nettie Evelyn Holly				4. DATE OF DEATH Month Day Year JANUARY 23 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/8/1898	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Loganville Construction		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME GEORGE J Holly			
14. MOTHER'S MAIDEN NAME FLORENCE HAMMOND				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Address Mrs. Chester M Reynolds, Oxford, Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca. in liver and mesenteric 153.3 DUE TO lymph nodes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of sigmoid colon DUE TO 3 yrs (Had Surgery) (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> not work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Dec 30th , 19 58 , to 1/23 , 19 59 , that I last saw the deceased alive on 1/23rd , 19 59 , and that death occurred at 6:35 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.				DATE SIGNED 1/23/59			
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave. Harford, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/26/59		22b. DATE THEREOF 1/26/59		22c. NAME OF CEMETERY OR CREMATORY Harford		22d. LOCATION (City, town, or county) (State) New Port Deposit Md	
23. FUNERAL DIRECTOR'S SIGNATURE William L. Evans				24a. REC'D BY REGISTRAR DATE JAN 27 '59		24b. REGISTRAR'S SIGNATURE William L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

710

CERTIFICATE OF DEATH

00685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New York City b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Bel Air,		c. LENGTH OF STAY IN lb 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home		d. STREET ADDRESS 69X-3	
3. NAME OF DECEASED (Type or print) First MARIE Middle — Last HOZA		4. DATE OF DEATH Month Jan. Day 8 Year 1959	
5. SEX Fem.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1887
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress Maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hoza		14. MOTHER'S MAIDEN NAME Stetkarova	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 082-22-5796	
17. INFORMANT Frank Benisek		Address Belcamp, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia-hypostatic 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. hypertensive cardio-vascular disease DUE TO (c) Cerebral hemorrhage with left hemiparesis. (9/20-58)		INTERVAL BETWEEN ONSET AND DEATH ??	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 29, 1957 , to Jan. 1, 1959 , that I last saw the deceased alive on Jan. 1, 1959 , and that death occurred at 11:20 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED 1-2-59			
ACTUAL SIGNATURE Willard P. Hudson		PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Jan-5-1959	
22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore - Md	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. W. Woberton		24a. REC'D BY REGISTRAR DATE	
ADDRESS Funeral Home Inc 6306-Belair Rd., Baltimore -6, Md		24b. REGISTRAR'S SIGNATURE Carlton S. Kneen	

CERTIFICATE OF DEATH

770

<p>1. Name of deceased: John Doe</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: Jan. 1, 1900</p>		<p>4. Age: 23 years</p>	
<p>5. Date of death: Jan. 1, 1923</p>		<p>6. Place of death: Home</p>	
<p>7. Cause of death: Heart disease</p>		<p>8. Immediate cause: Myocardial infarction</p>	
<p>9. Duration of illness: 2 weeks</p>		<p>10. Medical history: None</p>	
<p>11. Name of physician: Dr. J. H. Smith</p>		<p>12. Signature of physician: <i>[Signature]</i></p>	
<p>13. Name of registrar: John Doe</p>		<p>14. Signature of registrar: <i>[Signature]</i></p>	

679

CERTIFICATE OF DEATH

00686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Darlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Clement</u> Middle <u>Morton</u> Last <u>Hutchinson</u>		4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES EXECUTIVE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. New Jersey</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MORTON CLEMENT HUTCHINSON, SR.</u>		14. MOTHER'S MAIDEN NAME <u>Kathleen E. Honeyey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or date of service) <u>1913-1929</u>		16. SOCIAL SECURITY NO. <u>103-12-7822</u>	
17. INFORMANT <u>Morton Hutchinson</u>		Address <u>Darlington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic lymphocytic leukemia</u> <u>204.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>48</u> , to <u>Jan</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Jan</u> 19 <u>59</u> , and that death occurred at <u>11:55</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u>		ADDRESS (Street, city or town, state) <u>Darlington Md</u> DATE SIGNED <u>1/19/59</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>		<u>DARLINGTON, MD</u>	
22a. REMOVAL, CREMATION, OR BURIAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 20, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

028

Rev. 0-10-18

April 11, 18 00

*Richardson, Thomas
Dying at home*

James Spafford Perkins

*John Spafford Perkins
M.D. Bailey, M.D.*

711

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel - Air</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.D. Bel - Air</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>CLARENCE</i> Middle <i>A.</i> Last <i>JACKSON</i>				4. DATE OF DEATH Month <i>1</i> Day <i>8</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 25, 1900</i>	
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months <i>4</i> Days <i>13</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm worker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Cattle farm</i>		11. BIRTHPLACE (State or foreign country) <i>Churchville, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>George Jackson</i>				14. MOTHER'S MAIDEN NAME <i>Eliana Wiggins</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give year or dates of service) <i>World War I</i>				16. SOCIAL SECURITY NO. <i>218-30-6207</i>		17. INFORMANT <i>Mrs Stella E. Jackson</i> Address <i>Rock Spring Rd Bel - Air, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>445X Cerebro- resp. failure</i>							<i>1 day</i>
DUE TO (b) <i>Pneumonia</i>							<i>2 days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Apoplexy (Malignant hypertension) 8 yrs</i>							<i>6 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>6 Jan</i> , 19 <i>59</i> , to <i>8 Jan</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8 Jan</i> , 19 <i>59</i> , and that death occurred at <i>6:15 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H.P. Sidwell</i>				ADDRESS (Street, city or town, State) <i>401 Franklin St. Baltimore Md</i>			
DATE SIGNED <i>Jan 9</i>							
PHYSICIAN'S NAME (Type) <i>H. P. SIDWELL</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/12/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Tabernacle Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Benson, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullock</i>				ADDRESS <i>Harold St. Md</i>		24a. REC'D BY REGISTRAR <i>JAN 13 '59</i>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



100

680

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PA.</u> b. COUNTY <u>YORK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvee de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELTA</u> <u>75x3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>MAIN</u>	
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>ANN</u> Last <u>Kilgore</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1958</u>
9. AGE (In years last birthday) yrs. <u>7</u> Months <u>27</u> Days <u>27</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>chad</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oscar S. Kilgore</u>		14. MOTHER'S MAIDEN NAME <u>Audrey Wiley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>OSCAR KILGORE, DELTA, PA.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>571.0</u> DUE TO <u>Enteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>May 25, 1958</u> , to <u>Jan 21, 1959</u> , that I last saw the deceased alive on <u>Jan 21, 1959</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert Barthel</u>		ADDRESS (Street, city or town, state) <u>FOREST HILL, MD</u> DATE SIGNED <u>Jan 21, 1959</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT BARTHEL</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PINE GROVE</u>	22d. LOCATION (City, town, or county) (State) <u>SUNNYBURN, YORK CO., PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u> ADDRESS <u>DELTA, PA.</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u>JAN 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2001252XV6

681

CERTIFICATE OF DEATH

00689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cal</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. LENGTH OF STAY IN 1b <u>2 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Colora</u> <u>07X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last <u>Kyle</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 29, 1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William Edward Kyle</u>			
14. MOTHER'S MAIDEN NAME <u>Jennie Lynch</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>John Kyle - son Colora, Md.</u>				17. INFORMANT Address <u>John Kyle - son Colora, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERITONITIS</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RUPTURE OF BLADDER + PELVIC ABSCESS</u> DUE TO (c) <u>NOBULAR PROSTATIC HYPERPLASIA</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-11-59</u> , to <u>1-13-59</u> , that I last saw the deceased alive on <u>1-13-59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. K. Brendle</u>				ADDRESS (Street, city or town, state) <u>Harford, Md.</u> DATE SIGNED <u>1-14-59</u>			
PHYSICIAN'S NAME (Type) <u>Wm. K. BRENDLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-17-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Conowingo, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herman E. McMillen</u>				24a. REC'D BY REGISTRAR <u>Rising Sun, Md.</u> DATE <u>JAN 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

682

CERTIFICATE OF DEATH

00650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>158 Royal Terrace</u>		d. STREET ADDRESS <u>158 Royal Terrace</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>H.</u> Last <u>Logg</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 21-1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lafe Higdon</u>		14. MOTHER'S MAIDEN NAME <u>Molly Furtkouser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>433-18-2634</u>	
17. INFORMANT <u>Harry K. Hardin Fairdale Ky</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 Hrs.</u> <u>Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11:30 AM 1/19, 1959</u> , to <u>6:45 PM 1/19, 1959</u> , that I last saw the deceased alive on <u>Jan 19, 1959</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Kirby Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>617 W. Belair Ave.</u>	
DATE SIGNED <u>Jan 20, 1959</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>1/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louisville Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Louisville Kentucky</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Barriag</u> ADDRESS <u>Aberdeen, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hous</u>	

683

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> o. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Mem. Hospital</u>				e. STREET ADDRESS <u>RD II 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Sarah</u> Last <u>Little</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 19 1988</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Curry</u>				14. MOTHER'S MAIDEN NAME <u>SARAH JANE CANTLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. KATHIE F. PYLE HAVRIE DE GRACE MD R.D.#1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>S'Neumania</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>2 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-31</u> , 19 <u>59</u> to <u>1-30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>January 30, 1959</u> , and that death occurred at <u>10:50</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmond H. Woodman</u> M.D.				ADDRESS (Street, city or town, state) <u>401 S. Union Ave, Harre de Grace, Md.</u> DATE SIGNED <u>1/31/59</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb. 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>HARRE DE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harre de Grace, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>FEB 3 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

34

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
712 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle J.H. Last Lyons		4. DATE OF DEATH Month January Day 28 Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1931
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min. 27	IF UNDER 24 HRS. Months 27 Days 27 Hours 27 Min. 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Jess A. Lyons		14. MOTHER'S MAIDEN NAME Elizabeth Porter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes 1952		16. SOCIAL SECURITY NO. 216-28-9181	
17. INFORMANT Mrs. Elizabeth Anderson, Joppa, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Sclerosis with Coronary Thrombosis of Left Anterior Descending Artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 29, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 31, 1959	22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran	22d. LOCATION (City, town, or county) (State) Joppa, Harford, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McConny		24a. REC'D BY REGISTRAR FEB 2 '59	
ADDRESS Abingdon, Maryland.		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

110

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

X

Nov. 21, 1931

Yes 1932 210-08-9181 Mrs. Elizabeth Anderson, Johns, Maryland
 Jess A. Lyons
 Metal Worker Automobile Maryland U.S.A.,
 Elizabeth Porter

3rd 1 Jan. 31, 1932 Trinity Lutheran
 Arlington, Maryland.
 Johns, Harford, Maryland.

684

CERTIFICATE OF DEATH

00693

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>			
3. NAME OF DECEASED (Type or print) First <u>ALLEN</u> Middle <u>IRVIN</u> Last <u>MANAHAN</u>				4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 6, 1958</u>	
9. AGE (In years lost birthday) yrs. <u>7</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>HAUREDE GRACE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELLSWORTH MANAHAN</u>				14. MOTHER'S MAIDEN NAME <u>MARY JANE LEONARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>ELLSWORTH MANAHAN, WHITEFORD, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EDEMA</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTYREXIA</u> DUE TO (c) <u>OVERWHELMING VIRAL INFECTION (? PNEUMONIA)</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>JAN. 14, 1959</u> , to <u>JAN. 14, 1959</u> , that I last saw the deceased alive on <u>JAN. 14, 1959</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hartford Mem. Hosp.</u> DATE SIGNED <u>Arthur S. Harris</u>							
ACTUAL SIGNATURE <u>Arthur S. Harris</u> M.D.				PHYSICIAN'S NAME (Type) <u>Arthur S. Harris</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>DELTA, PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u> ADDRESS <u>Delta, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

2001203XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10003

CERTIFICATE OF DEATH

884

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1884		5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School		11. SERVICE None		12. SOCIAL SECURITY NUMBER 1-1-1-1-1-1	
13. DECEASED AT HOME Yes		14. PLACE OF DEATH Home		15. DATE OF DEATH 1945		16. TIME OF DEATH 10:00 AM		17. CAUSE OF DEATH Heart Disease		18. MANNER OF DEATH Natural	
19. SIGNATURE OF DECEASED James H. Harris		20. SIGNATURE OF WITNESS John Doe		21. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Harris		22. SIGNATURE OF PHYSICIAN Dr. John Smith		23. SIGNATURE OF CORONER John Doe		24. SIGNATURE OF BURIAL OFFICER John Doe	
25. PLACE OF BURIAL St. Mary's Cemetery		26. DATE OF BURIAL 1945		27. TIME OF BURIAL 10:00 AM		28. NAME OF FUNERAL HOME John Doe		29. NAME OF CEMETERY St. Mary's Cemetery		30. NAME OF MINISTER John Doe	

00694

Reg. Dist. No.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. CITY OR TOWN <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre Grace</u>		c. LENGTH OF STAY IN 1b <u>24</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank - Mary J.</u>		4. DATE OF DEATH Month Day Year <u>11/17/59</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Delayed Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Mary P.</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Student</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Della Mary</u>		Address <u>3 Chesapeake Drive Havre Grace Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY INSUFFICIENCY</u> (c) <u>BRONCHIOGENIC CARCINOMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u> <u>1 WEEK</u> <u>6 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 8, 1958</u> , to <u>JAN 17, 1959</u> , that I last saw the deceased alive on <u>JAN 17, 1959</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. P. Ross</u>		DATE SIGNED <u>11/21/59</u>	
PHYSICIAN'S NAME (Type) <u>I. R. Ross</u>		<u>HAURE DE GRACE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/30/59</u>		22b. DATE THEREOF <u>Angel Hill</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Havre Grace Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. ...</u>		ADDRESS <u>...</u>	
24a. REC'D BY REGISTRAR <u>JAN 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1982

DEPT. OF HEALTH
BALTIMORE, MD.
1000
1000

<p>1. Name of deceased: _____</p>	
<p>2. Date of death: _____</p>	
<p>3. Place of death: _____</p>	
<p>4. Cause of death: _____</p>	
<p>5. Signature of physician: _____</p>	
<p>6. Signature of registrar: _____</p>	
<p>7. Date of registration: _____</p>	
<p>8. Registrar's office: _____</p>	
<p>9. Remarks: _____</p>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00695

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>3m</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA office Dr. G. C. Palmer</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Lee Morrison</u>		4. DATE OF DEATH <u>January 18 19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21, 1958</u>
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR <u>2</u> Months <u>27</u> Days <u>2</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.,</u>	
13. FATHER'S NAME <u>Avis W. Morrison</u>		14. MOTHER'S MAIDEN NAME <u>Jessie G. Dowell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Avis W. Morrison, Aberdeen R.D., Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity (8mo) @ Aut. Mycosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED <u>1-18-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 20, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Free Will Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard A. Williams</u>		24a. REC'D BY REGISTRAR <u>JAN 22 1959</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

DATE OF DEATH
PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

Oct. 21, 1959

none

none

Harford Co., Md.

U.S.A.

W. Morrison

Jessie G.

no

none

Avis W. Morrison, Aberdeen, R.D., Md.

Burial

Jan. 20, 1959

Free Will Baptist

Bel Air, Harford, Maryland.

Aberdeen, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00696

Reg. Dist. No.

687

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u> 46X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>821 Elkton Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Newell</u> ^{First} LAST Middle	4. DATE OF DEATH <u>January</u> Month <u>6</u> Day <u>19</u> Year <u>59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-1917</u>
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Mgr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	11. BIRTHPLACE (State or foreign country) <u>Vermont</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Guy Newell</u>		14. MOTHER'S MAIDEN NAME <u>Marion Goneo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>008-12-1025</u>	
17. INFORMANT <u>Velma Newell</u> Address <u>821 Elkton Road</u>		<u>Newark, Delaware</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound, comminuted fracture skull</u> <u>819X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto - object left</u>	
20c. TIME OF INJURY Month, Day, Year <u>8</u> Hour <u>1-6</u> 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>131</u>	20f. (City or town) (County) (State) <u>Conowingo Harford Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED <u>1-7-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East Brookfield Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>East Brookfield, Vermont</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Newark</u> #1297 ADDRESS <u>Newark, Del.</u>		24a. REC'D BY REGISTRAR <u>JAN 12 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

1
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

713

CERTIFICATE OF DEATH

00697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. LENGTH OF STAY IN 1b 40 yrs.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Christina First Norris Middle Last		4. DATE OF DEATH Jan. Month 21 Day 1959 Year	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1889
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Joppa, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Robert H. Lomyer		14. MOTHER'S MAIDEN NAME Margaret Herbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles A. Norris, Address Edgewood Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno Carcinoma 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. , 19 56 to Jan. 21 , 19 59 , that I last saw the deceased alive on Jan. 19 , 19 59 , and that death occurred at 8 A. M. from the causes and on the date stated above. ACTUAL SIGNATURE William A. Tyson M.D. ADDRESS Kingville, Md. DATE SIGNED Jan. 21, 1959 PHYSICIAN'S NAME (Type) William A. Tyson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 24, 1959	
22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Joppa, Harford, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard S. McKenna Jr. ADDRESS Abingdon, Md.,		24a. REC'D BY REGISTRAR JAN 27 '59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

CERTIFICATE OF DEATH

Marion

Maryland

Marion

Wood

22 yrs.

Wood

of

Jan. 31, 1933

White

Female

U.S.A.

John, Md.

none

Housewife

Margaret Herbert

Robert E. Loper

Wood, Maryland

Charles A. Morris

none

Wife

no

John, Marion, Maryland

Trinity Lutheran

Jan. 1, 1933

Female

Abingdon, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00698

714

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magnolia				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magnolia			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle T. Last Oakley				4. DATE OF DEATH Month Jan. Day 3 Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1888		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,		11. BIRTHPLACE (State or foreign country) Magnolia, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas B. Oakley				14. MOTHER'S MAIDEN NAME Laura T. Crouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-22-0650		17. INFORMANT Fredericka Oakley, Magnolia, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstructive Emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/10 , 19 58 , to 1/12 , 19 59 , that I last saw the deceased alive on 1/3 , 19 58 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Louis Kahan		M.D. Box 966 Edgewood, Md.		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) E. Louis Kahan,		Edgewood, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McConn Jr		ADDRESS Abingdon, Maryland.		24a. REC'D BY REGISTRAR JAN 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kinner	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

688

CERTIFICATE OF DEATH

00699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>418 N. Freedom St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Peaco</u> Last <u>Peaco</u>		4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. BIRTHPLACE (State or foreign country) <u>Aberdeen, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>? Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Harriett French</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-12-1032</u>	
17. INFORMANT <u>Mrs. Lloyd Peaco, Harre de Grace, Md.</u>		Address <u>560 Girard St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Cerebral Thrombosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 20</u> , 19 <u>59</u> , to <u>Jan 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>59</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St., Harre de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>1/26/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. James A. M. E. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Harre de Grace, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>		ADDRESS <u>Harre de Grace</u>	
24a. REC'D BY REGISTRAR <u>JAN 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Hanes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

688

<p>1. Name of deceased: <i>WILLIAM EDWARD</i></p>	
<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of death: <i>Dec 10 1914</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart failure</i></p>	
<p>7. Duration of illness: <i>2 weeks</i></p>	
<p>8. Name of attending physician: <i>Dr. J. H. Smith</i></p>	
<p>9. Name of informant: <i>Wife</i></p>	
<p>10. Signature of informant: <i>[Signature]</i></p>	
<p>11. Signature of physician: <i>[Signature]</i></p>	
<p>12. Date of completion: <i>Dec 10 1914</i></p>	

689

CERTIFICATE OF DEATH

00760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Zera</u> Last <u>Phillips</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 1 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Howard Poteet</u>				14. MOTHER'S MAIDEN NAME <u>Mary Durham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Florence Regel-daught</u>				Address <u>Forest Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac DeCompensation</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal hypostatic pneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 9th</u> , 19 <u>59</u> , to <u>Jan 9th</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 9th</u> , 19 <u>59</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D.				ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harre de Grace, Md.</u>			
DATE SIGNED <u>1/9/59</u>							
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Brick Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Garrettsville Harford Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. W. Sperry</u>				ADDRESS <u>Garrettsville, Md.</u>			
24a. REC'D BY REGISTRAR <u>Jan 15 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Carroll L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

715

CERTIFICATE OF DEATH

00701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Perryman		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X (Rural) Perryman	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First CARRIE Middle JANE Last COLLINS PINION		4. DATE OF DEATH Month January Day 25 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/1866
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leven Collins		14. MOTHER'S MAIDEN NAME Caroline Mary Welsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George H. Pinion, Perryman, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) Hypertensive-Arteriosclerotic Heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/28 , 19 56 , to 1/25 , 19 59 , that I last saw the deceased alive on 1/23 , 19 59 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George T. Stansbury, M.D. 569 Revolution St. 1/28/59			
ACTUAL SIGNATURE George T. Stansbury		PHYSICIAN'S NAME (Type) George T. Stansbury	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/59	
22c. NAME OF CEMETERY OR CREMATORY Union M.E. Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John P. Stansbury		24a. REC'D BY REGISTRAR DATE JAN 29 '59	
ADDRESS Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE John P. Stansbury	

215

716

CERTIFICATE OF DEATH

00702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bel Air/Aberteen Road</u>		d. STREET ADDRESS <u>Bel Air/Aberteen Road</u>	
3. NAME OF DECEASED (Type or print) <u>Flora A. Phumner</u>		4. DATE OF DEATH Month <u>1</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nelson Anderson</u>		14. MOTHER'S M maiden NAME <u>Nachel Barnett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Piscero Phumner - Aberteen road</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO <u>Generalized Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>6 Years</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 1</u> , 19 <u>58</u> , to <u>JAN 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JAN 8</u> , 19 <u>59</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andre Weiss</u> M.D.		ADDRESS (Street, city or town, state) <u>114 W. Bel Air Av. Aberdeen, Md</u>	
DATE SIGNED <u>12 January 1959</u>			
PHYSICIAN'S NAME (Type) <u>ANDRE WEISS, MD.</u>		<u>114 W. Bel Air Ave.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Churchville Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Churchville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberteen Maryland</u>	
24a. RECORDING REGISTRAR <u>John G. Tarring</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawa</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00703

717

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - BEL Air</u>				c. LENGTH OF STAY IN 1b <u>26 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford County Home</u>				d. STREET ADDRESS <u>Toll Gate Road</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Prigg</u> Last <u>Prigg</u>				4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6, 1914</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Daniel Prigg</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Boardly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Clark E. Fitzpatrick, Address Hartford Co. Home Toll Gate Rd., BEL Air, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>1-26</u> , 19 <u>59</u> , to <u>1-29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-26</u> , 19 <u>59</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerald E Palmer</u>				ADDRESS (Street, city or town, state) <u>BEL Air, Md</u>			
NAME (Type) <u>Gerald E Palmer, MD</u>				DATE SIGNED <u>1-30-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hartford County Home Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>BEL Air R.D., Hartford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>W. Broadway + Williams St. BEL Air, Maryland</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

690

CERTIFICATE OF DEATH

00704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <u>Harford</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrod Chase Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrod Chase Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>417 Lodge</u>	
3. NAME OF DECEASED (Type or print) <u>James Peter Quomony</u> First Middle Last		4. DATE OF DEATH <u>1/5/59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/1905</u> 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ammer Handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Drug Store</u>	
11. BIRTHPLACE (State or foreign country) <u>York Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Volentine Quomony</u>		14. MOTHER'S MAIDEN NAME <u>Hanna F. Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Martha M. Quomony</u>		Address <u>417 Lodge Harrod Chase Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Cerebral Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>2/27</u> , 19 <u>58</u> , to <u>1/4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/4</u> , 19 <u>59</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>529 Revolution St., Harrod Chase Md.</u> DATE SIGNED <u>1/7/59</u>			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		M.D. <u>529 Revolution St., Harrod Chase Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1/8/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury</u>	22d. LOCATION (City, town, or county) (State) <u>Cal G. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donington / Rm. Harrod Chase Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film G238 2-13-59 et
718
CERTIFICATE OF DEATH

00705
182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-air Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Rural</u> <u>Rocks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Walter Nursing Home</u>				d. STREET ADDRESS <u>o George Anderson</u>			
3. NAME OF DECEASED (Type or print) <u>Rose</u> First <u>Reichert</u> Middle Last				4. DATE OF DEATH <u>Jan. 25</u> 19 <u>59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1867</u> <u>92</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Walter Nursing Home</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>arteriosclerotic heart dis-</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>11 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/11</u> , 19 <u>59</u> to <u>1/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/23</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Fork md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>				<u>FORK MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Jan. 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blenheim</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. A. Bailey</u> ADDRESS <u>Harlington</u>				24a. REC'D BY REGISTRAR <u>Feb 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

719 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Harford

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

Rural - Bel Air

LENGTH OF STAY (in this place)

20 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MarylandCOUNTY Harford

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

RuralBel Air

STREET ADDRESS

(If rural give location)

Gibson

3. NAME OF DECEASED (Type or Print)

(First) Nannie(Middle) Lava

(Last)

Rhodes

4. DATE OF DEATH

(Month)

(Day)

(Year)

January 11959

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH

January 15, 1893

9. AGE last birthday

65 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Floyd Wood

14. MOTHER'S MAIDEN NAME

Deane J. Baldwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)

No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Thomas E. Rhodes, Forest Hill, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X IMMEDIATE CAUSE (A)Acute pulmonary edema terminating in

INTERVAL BETWEEN ONSET AND DEATH

15 minutes

ANTECEDENT CAUSE(S) DUE TO

Disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

Chronic cardio-vascular with hypertension and5 years

DUE TO

(C)

Chronic decompensation.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

White

Not white

at work ☐at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1953, to Jan. 1, 1959, that I last saw the deceasedalive on Dec. 31, 1958, and that death occurred at 10:00 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

Willard P. Hudson M.D.Forest Hill, Md. January 2, '59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

1/3/59

NAME OF CEMETERY OR CREMATORY

Oak Grove Baptist

LOCATION (City, town, or county)

Bel Air, Maryland

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE JAN 5 '59W. E. RhodesJoseph P. Rhodes Bel Air Md

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. File No.

A. DEATH OF PERSON WHO WAS BORN IN

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

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DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

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PLACE OF DEATH

AGE AT DEATH

SEX

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EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

200-100-1100

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC FOR A FEE OF FIVE CENTS PER COPY. IT IS TO BE DESTROYED AFTER FIFTY YEARS.

691

CERTIFICATE OF DEATH

00707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Richardson</u> Last <u>Richardson</u>				4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 5, 1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Harre de Grace, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Robert Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Francis Sheridan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mr. Eugene Richardson</u>				Address <u>565 St Clair St Harre de Grace</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Hypertensive-Arteriosclerotic Heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>58</u> , to <u>1/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/27</u> , 19 <u>59</u> , and that death occurred at <u>12:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>569 Revolution St Harre de Grace, Md</u> DATE SIGNED <u>1/27/59</u> ACTUAL SIGNATURE <u>George T. Stansbury</u> PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/31/59</u>		<u>St. James Cemetery</u>		<u>Harre de Grace Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E Bullenk</u>				ADDRESS <u>Harre de Grace Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100717

CERTIFICATE OF DEATH

1931

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]		DATE OF BIRTH [Faint text, possibly "Jan 15 1886"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "Jan 20 1931"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
NAME OF PHYSICIAN [Faint text]		NAME OF REGISTRAR [Faint text]		NAME OF WITNESS [Faint text]	
ADDRESS OF PHYSICIAN [Faint text]		ADDRESS OF REGISTRAR [Faint text]		ADDRESS OF WITNESS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF NEXT OF KIN [Faint text]		SIGNATURE OF OTHER [Faint text]	
NAME OF DECEASED [Faint text]		NAME OF NEXT OF KIN [Faint text]		NAME OF OTHER [Faint text]	
ADDRESS OF DECEASED [Faint text]		ADDRESS OF NEXT OF KIN [Faint text]		ADDRESS OF OTHER [Faint text]	

RECEIVED BY THE REGISTRAR OF DEATHS
 TO BE FILED IN THE DEPARTMENT OF HEALTH
 BALTIMORE, MD
 JAN 20 1931

692

CERTIFICATE OF DEATH

00708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Havre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		1. d. STREET ADDRESS <u>734 Okego St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Olivia</u> Middle <u>Richardson</u> Last <u>Richardson</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-12-1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u> Hours <u>--</u> Min. <u>--</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chesapeake Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Lloyd Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bowser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Mrs. Lewis V. Richardson - Havre de Grace, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive-Arteriosclerotic Heart disease</u> DUE TO (c) <u>Hypertensive-Arteriosclerotic Heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>--</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>--</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/10</u> , 19 <u>58</u> , to <u>1/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/6</u> , 19 <u>59</u> , and that death occurred at <u>12:00 Noon</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>562 Revolution St. Havre de Grace, Md.</u> DATE SIGNED <u>1/7/59</u> ACTUAL SIGNATURE <u>George T. Stansbury</u> PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-10-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Havre de Grace, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer T. Bulluck</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>JAN 13 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible text from bleed-through]

693

CERTIFICATE OF DEATH

00709

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERD HILL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>RD# 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>de</u> Last <u>Sampson</u>		4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 6, 1911</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md Harford Co</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lewis Denham</u>		14. MOTHER'S MAIDEN NAME <u>Annie L. Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-05-3169</u>	
17. INFORMANT <u>Geo. Sampson</u>		Address <u>P.O. Box 186 Grand Island, N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>status epilepticus (convulsion)</u> 353.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Portal cirrhosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>0</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>January 30</u> , 19 <u>59</u> , and that death occurred at <u>1:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James McC. Finney</u>		DATE SIGNED <u>1-31-59</u>	
PHYSICIAN'S NAME (Type) <u>H. S. Bailey, Carlington, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Feb 2, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cn</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey, Carlington, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finney</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

720

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa				c. LENGTH OF STAY IN 1b 14 yrs.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Anderson Last Seaman				4. DATE OF DEATH Month Jan. Day 13. Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1894	
9. AGE (In years last birthday) 64 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.,				13. FATHER'S NAME Charles T. Seaman			
14. MOTHER'S MAIDEN NAME Laura Anderson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 1			
16. SOCIAL SECURITY NO. 215-09-3632				17. INFORMANT Mrs. Barbara W. Seaman, Joppa, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Transverse Colon 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Edgewood, Maryland				20g. (County) (State)			
21. I certify that I attended the deceased from 12/1 , 19 58 , to 1/13 , 19 59 , that I last saw the deceased alive on 1/13 , 19 59 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Louis Kahan M.D.				DATE SIGNED Box 966 Edgewood, Md.			
PHYSICIAN'S NAME (Type) Louis E. Kahan				ADDRESS Edgewood, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15, 1959		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard A. McConna Jr.				ADDRESS Abingdon, Md.,		24a. REC'D BY REGISTRAR DATE JAN 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoms							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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694

CERTIFICATE OF DEATH

00711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>HARFORD</u> <u>Maryland</u> STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u> 24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hospital</u>				d. STREET ADDRESS <u>656 Franklin</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA ARMOR SENTMAN</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 14 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/24/1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE FREDERICK ARMOR</u>				14. MOTHER'S MAIDEN NAME <u>JENNY DICKY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>656 Franklin St. Harford Grace Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis - myocarditis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/14</u> , 19 <u>56</u> , to <u>1/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>59</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harford Grace Md.</u> DATE SIGNED <u>1-16-59</u>							
ACTUAL SIGNATURE <u>C. L. Lewis</u>				PHYSICIAN'S NAME (Type) <u>Dr. Lewis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Lewis</u>				ADDRESS <u>Harford Grace Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 20 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

721

CERTIFICATE OF DEATH

00712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle O. Last Sparks		4. DATE OF DEATH Month Jan. Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July, 15, 1882
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME William Sparks		14. MOTHER'S MAIDEN NAME Mary Moxley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Clittis Moxley, Joppa, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cerebrovascular and Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) C.V.A. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/7 , 19 57 , to 1/16 , 19 59 , that I last saw the deceased alive on 1/16 , 19 59 , and that death occurred at 4:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Louis Kahan M.D.		ADDRESS (Street, city or town, state) Box 966 Edgewood, Md DATE SIGNED	
PHYSICIAN'S NAME (Type) E. Louis Kahan		Edgewood, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/18/1959	
22c. NAME OF CEMETERY OR CREMATORY Moody Funeral Home		22d. LOCATION (City, town, or county) (State) Mount Airy, Surry, N.C.,	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCormick		ADDRESS Abingdon, Maryland	
24a. REC'D BY REGISTRAR DATE JAN 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kahan	

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On 17th, 18th, 19th

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

722

CERTIFICATE OF DEATH

00713

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MORTON</u> Middle <u>PAUL</u> Last <u>TAYLOR</u>		4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negroid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 11, 1959</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ulysses Morton Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Elisabeth Waltrudis Renz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Morton Ulysses M. Taylor</u>		Address <u>1 Liberty, Aberdeen, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apnea Neonatorum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Hemorrhagic Disease of Newborn, Prematurity</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 11, 1959</u> , to <u>January 12, 1959</u> , that I last saw the deceased alive on <u>January 12, 1959</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Army Hosp, Aberdeen Proving Gnd.</u> <u>Jan 12, 1959</u>			
ACTUAL SIGNATURE <u>Thomas J. Fraher</u>		M.D. <u>U.S. Army Hosp, Aberdeen Proving Gnd.</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS J. FRAHER, Capt, MC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-15-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U.S. Government Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Proving Ground, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Fraher</u>		ADDRESS <u>Harford County, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraher</u>	

CERTIFICATE OF DEATH

MINNESOTA
BUREAU OF VITAL RECORDS

13 JAN 1959 11 32 Z

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE,
695
CERTIFICATE OF DEATH

00714

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		d. STREET ADDRESS <u>801 ONTARIO, ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>801 ONTARIO, ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE FRANCES WERNER</u>		4. DATE OF DEATH Month Day Year <u>JAN. 11 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 26, 1974</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WERNEP SR.</u>		14. MOTHER'S MAIDEN NAME <u>REGINA SITZLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MR. A. HUGHES SPENCER, HAVRE DE GRACE MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Insufficiency</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 10</u> 19 <u>58</u> to <u>JAN 11</u> 19 <u>59</u> , that I last saw the deceased alive on <u>JAN 10</u> 19 <u>58</u> , and that death occurred at <u>3 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>DR. R. L. W. [Signature]</u> M.D. <u>DR. R. L. W. [Signature]</u> 1/12/59			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-13-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>HAVRE DE GRACE MD.</u>	
24a. REC'D BY REGISTRAR <u>JAN 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1945	
AGE		SEX	
65		Male	
RACE		COLOR	
White		White	
BIRTH DATE		PLACE OF BIRTH	
JANUARY 1, 1880		BALTIMORE, MARYLAND	
MARRIAGE DATE		MARRIAGE PLACE	
JANUARY 1, 1905		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH	
Retired		Heart Disease	
PREVIOUS ILLNESS		IMMEDIATE CAUSE OF DEATH	
None		Myocardial Infarction	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
JANUARY 15, 1945		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 15, 1945		JANUARY 15, 1945	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE
 AND THE MARYLAND DEPARTMENT OF HEALTH - ANNAPOLIS
 AND THE MARYLAND DEPARTMENT OF HEALTH - PRAIRIE GROVE
 AND THE MARYLAND DEPARTMENT OF HEALTH - ROCKVILLE
 AND THE MARYLAND DEPARTMENT OF HEALTH - WASHINGTON, D.C.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

723

CERTIFICATE OF DEATH

00715

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Rocks</u> (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place) <u>61 years</u>		CITY OR TOWN <u>Rocks</u> (If outside corporate limits, write RURAL and give nearest town)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route #24</u>				STREET ADDRESS <u>Route #24</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>JAMES CLARENCE Wilson</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>JAN. 8, 1959</u> (Month) (Day) (Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Sept. 20, 1874</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>	
13. FATHER'S NAME <u>Samuel Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Mary McAlister</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>FRANCES W. Hince, Rocks, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>443X MALNUTRITION AND PULMONARY EDEMA</u>						<u>2 WKS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>SENILE PSYCHOSIS</u>						<u>6 to 8 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>HYPERTENSIVE ARTERIO SCLEROTIC CARDIO-VASCULAR OVERLOADS</u>						<u>DISEASE</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN. 7, 1959</u> , to <u>JAN. 8, 1959</u> , that I last saw the deceased alive on <u>JAN. 7, 1959</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Hume</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN. 10, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Cross Episcopal Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rocks, Harford Co., Md.</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 12 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway + W. Williams St. Bel Air, Maryland</u>			

